NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 25, 2019

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Joseph Michael Pober, M.D.
975 Park Avenue
New York, New York 10028

Re: License No. 144489

Dear Dr. Pober:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 19-063. This order and any penalty provided therein goes into effect April 1, 2019.

Please direct any questions to: Board for Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204, telephone # 518-402-0846.

Sincerely,

[redacted]

Robert A. Catalano, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Michael Smikun, Esq.
Robert Solomon, Esq.
Callagy Law, P.C.
Mack-Cali Centre II
650 From Road, Suite 565
Paramus, New Jersey 07652

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 19-063

IN THE MATTER OF JOSEPH MICHAEL POBER, M.D.	CONSENT ORDER

Upon the application of (Respondent) JOSEPH MICHAEL POBER, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR

upon facsimile transmission to Respondent or Respondent's attorney,

whichever is first.

SO ORDERED.

DATE: 03/21/2019

[redacted]

ARTHUR S. HENGERER, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JOSEPH MICHAEL POBER, M.D.	CONSENT AGREEMENT

JOSEPH MICHAEL POBER, M.D., represents that all of the following statements are true:

That on or about November 7, 1980, I was licensed to practice as a physician in the State of New York, and issued License No. 144489 by the New York State Education Department.

My current address is 975 Park Avenue New York, New York 10028, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

The New York State Board for Professional Medical Conduct (Board) has issued a Determination and Order (BPMC #19-003, marked as Exhibit "A", attached hereto and a part of this Consent Agreement) sustaining five specifications of professional misconduct. An appeal to the Administrative Review Board of the State Board of Professional Medical Conduct ("ARB") is currently pending. I make this application in the interest of resolving the matter without final action of the ARB.

Based upon the findings and conclusions set forth in the Determination and Order, I consent to the modification of the penalty set forth therein to read as follows.

- Pursuant to PHL § 230-a(2)(a), the Respondent's license to practice medicine shall be suspended, wholly, for a fixed period of nine months. Said nine-month period of suspension shall run from the effective date of the Determination and Order. (January 11, 2019).

- Pursuant to PHL §230-a (8), the Respondent shall be required during the nine-month period of suspension to complete courses of medical education in the subject areas of coding, pain management, clinical documentation and controlled substances, which courses of medical education shall be proposed by the Respondent and shall be subject to the prior written approval of the Director of OPMC.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall comply with each and every penalty imposed by this Order pursuant to N.Y. Pub. Health Law § 230-a; and

That Respondent shall comply with the practice conditions set forth in Exhibit B for a five-year period that shall commence at the end of the period of license suspension.

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

1. That Respondent shall remain in continuous compliance with all requirements of N.Y. Pub. Health Law § 2995-a(4) and 10 NYCRR 1000.5, including but not limited to the requirements that a licensee shall: report to the Department all information required by the Department to develop a public physician profile for the licensee; continue to notify the Department of any change in profile information within 30 days of any change (or in the case of optional information, within 365 days of such change); and, in addition to such periodic reports and notification of any changes, update his or her profile information within six months prior to the expiration date of the licensee's registration period. Licensee shall submit changes to his or her physician profile information either electronically using the

Department's secure web site or on forms prescribed by the Department, and licensee shall attest to the truthfulness, completeness and correctness of any changes licensee submits to the Department. This condition shall take effect 30 days after the Order's effective date and shall continue so long as Respondent remains a licensee in New York State. Respondent's failure to comply with this condition, if proven and found at a hearing pursuant to N.Y. Pub. Health Law § 230, shall constitute professional misconduct as defined in N.Y. Educ. Law § 6530(21) and N.Y. Educ. Law § 6530(29). Potential penalties for failure to comply with this condition may include all penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, including but not limited to: revocation or suspension of license, Censure and Reprimand, probation, public service and/or fines of up to $10,000 per specification of misconduct found; and

That Respondent shall comply with the requirements for closure of a medical practice that apply to when a licensee's medical license has been suspended without stay for more than one-hundred eighty (180) days as set forth in Public Health Law § 230(10)(h)(i) and (ii).

That Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719, with the following information, in writing, and

ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information. This condition shall take effect 30 days after the Order's effective date and shall continue at all times until Respondent receives written notification from the Office of Professional Medical Conduct, Physician Monitoring Program, that OPMC has determined that Respondent has fully complied with and satisfied the requirements of the Order, regardless of tolling;

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall

take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on

the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed modification, sanction, and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement that was executed upon my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of further litigation on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 3/14/19

[redacted]

JOSEPH MICHAEL POBER, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: _____

[redacted]
MICHAEL J. SMIKUN, ESQ.
Callegy Law, P.C., ESQ.
Attorney for Respondent

DATE: 3/15/19

[redacted]
DANIEL GUENZBURGER
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 3/21/19

[redacted]
KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT "A"

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 4, 2019

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Michael J. Smikun, Esq.
Callagy Law, P.C.
Mack-Cali Centre II
650 From Road, Suite 565
Paramus, New Jersey 07652

Paul E. Walker, Esq.
Attorney at Law
315 West 106th Street, Suite 1A
New York, New York 10025

Joseph Michael Pober, M.D.
975 Park Avenue
New York, New York 10028

RE: In the Matter of Joseph Michael Pober, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 19-003) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (l), (McKinney Supp. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

[redacted]

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: nm
Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JOSEPH MICHAEL POBER, M.D.	:	DETERMINATION AND ORDER BPMC-19-003

Pursuant to Public Health Law (PHL) § 230(10)(d)(i), the New York State Department of Health, Bureau of Professional Medical Conduct (Department) served Joseph Michael Pober, M.D. (Respondent) with a Notice of Hearing and Statement of Charges dated April 27, 2018. The Department subsequently served the Respondent with an amended Statement of Charges dated June 29, 2018. A copy of the Notice of Hearing and amended Statement of Charges is attached to this Determination and Order as Appendix I. This hearing was held at the offices of the New York State Department of Health, located at 90 Church Street, New York, New York. Pursuant to PHL § 230(10)(e), STEVEN M. LAPIDUS, M.D., Chairperson, THOMAS T. LEE, M.D., M.B.A., and ELENA M. COTTONE, P.A.-C., duly designated members of the State Board for Professional Medical Conduct, served as the hearing committee in this matter. NATALIE J. BORDEAUX, ADMINISTRATIVE LAW JUDGE, served as the administrative officer.

The Department appeared by Daniel Guenzburger, Associate Counsel. The Respondent appeared by Michael J. Smikun, Esq. of Callagy Law, P.C., Paul E. Walker, Esq., and Ralph

Erbaio, Esq.[1] Evidence was received, witnesses were sworn or affirmed, and a transcript of the proceeding was made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Notice of Hearing and Statement of Charges:	April 27, 2018
Pre-Hearing Conference:	May 22, 2018
Amended Statement of Charges:	June 29, 2018
Hearing Dates:	June 15, 2018 July 11, 2018 September 25, 2018 September 26, 2018
Submission of Briefs:	November 21, 2018
Deliberation Date:	December 4, 2018

STATEMENT OF THE CASE

The Department charged the Respondent with sixteen specifications of professional misconduct under NY Educ. Law § 6530, specifically: practicing the profession of medicine fraudulently (Educ. Law § 6530(2)); willfully making or filing a false report (Educ. Law § 6530(21)); practicing the profession of medicine with negligence on more than one occasion (Educ. Law § 6530(3)); practicing the profession of medicine with incompetence on more than one occasion (Educ. Law § 6530(5)); ordering excessive treatment not warranted by the

[1] Ralph Erbaio, Esq. appeared on the Respondent's behalf for the May 22, 2018 pre-hearing conference and June 15, 2018 hearing date only. Michael J. Smikun, Esq. and Paul E. Walker, Esq. appeared on the Respondent's behalf for all hearing dates.

condition of the patient (Educ. Law § 6530(35)); and engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice (Educ. Law § 6530(20)).

The Respondent denied each of the factual allegations and specifications.

FINDINGS OF FACT[2]

Citations in parentheses, which refer to transcript page number ("T") and exhibits that were accepted into evidence, represent evidence found persuasive by the Hearing Committee in arriving at a particular finding.

1. The Respondent is a board-certified plastic surgeon who was authorized to practice medicine in the State of New York on or about November 7, 1980, by the issuance of license number 144489. (Resp. Exhibit B; Dept. Exhibit 2.)

PATIENT A

2. From May 2008 through January 2011, the Respondent performed multiple plastic surgery procedures on Patient A (a 25-year-old male at the inception of treatment), including two body contouring procedures and over 40 excisional biopsies of lesions. (Dept. Exhibit 3; T 60, 300, 518-19.)

3. When a patient has pigmented skin lesions, a prudent plastic surgeon must decide whether to observe the lesions for changes or excise the lesions. In determining whether to excise a lesion, plastic surgeons often examine the lesions using the "ABCDE" criteria: asymmetry, border, color, distance or width of the lesion criteria, and evolution of the lesion. However, practitioners may also review other aspects of the lesion to evaluate the need for excision. Pigmented skin lesions are excised to prevent them from spreading locally, regionally, or throughout the body and becoming metastatic or cancerous. (T 35-37, 260, 287-88.)

[2] All findings in this section are unanimous.

4. Although the notes and operative reports pertaining to Patient A identify the closure procedures performed as flap reconstructions and advancement flaps respectively, the records do not describe how the flaps were created. (Dept. Exhibit 3; T 60, 300, 518-19.)

5. Advancement flaps are formed by lifting up the skin with hooks, undermining the skin with scissors or a knife to separate the subcutaneous tissue from the fascia of the muscle, usually making parallel incisions on the undersurface of the dermis to enable the area to break more loosely than a complex repair, and then sewing the separated tissue together. (T 43-44, 300.)

6. On or about and between January 23, 2009 through January 3, 2011, the Respondent submitted 25 claims for payment to Patient A's insurer pertaining to the removal of Patient A's lesions for testing and closure of the resulting wounds. The Respondent's submitted claims characterized these wound closures as pedicle flaps under CPT codes 15570-15576 (the 15570 series of codes,) procedures requiring the formation of a direct or tubed pedicle, with or without transfer. CPT (Common Procedural Technology) codes are a numerical listing of codes for any procedure performed by a physician in the practice of medicine. (Dept. Exhibits 4, 5, 15; T 56.)

7. From May 17, 2010 through January 19, 2011, the Respondent prescribed Patient A high dosages of opioid pain medication (Percocet, Vicodin, and hydrocodone), generally issuing the prescriptions before planned surgeries. The number of opioid pain medication pills prescribed in this period totaled 947. In January 2011 alone, the Respondent issued two prescriptions for Percocet 10 mg (the highest dosage available) to Patient A within 16 days for a total of 240 tablets. The Respondent did not document the patient's pain, his prior drug history or his tolerance to the prescribed pain medications. (Dept. Exhibits 3 and 6; T 69-71, 682.)

8. On February 14, 2011, Patient A sought a second opinion from melanoma expert Dr. Stephen Wang at Memorial Hospital for Cancer and Allied Diseases regarding the need for

additional excisions of pigmented spots on his skin. Dr. Wang concluded that the lesions, which he characterized as "dysplastic nevi," appeared to be benign. His opinion did not change after performing complete cutaneous examinations of Patient A during follow-up visits on August 19, 2011 and March 2, 2012. (Dept. Exhibit 7.)

9. On or about February 16, 2011, the Respondent advised Patient A of a 5-15% risk that the dysplastic nevi on his body would convert to melanoma and recommended a series of further excisional biopsies, a recommendation with which Patient A expressed his disagreement. The Respondent memorialized this exchange in writing and maintained the document in Patient A's medical record. (Dept. Exhibit 3, p. 86.)

10. On February 16, 2011, a surgical technician employed by the Respondent inserted the following information in Patient A's progress notes:

> Today, and at times in the past several months, momentary episodes of aggression with [Patient A] that are highly unusual from his personality of the past years. He has been requesting from myself and other members of the staff...prescriptions for pain medication (Vicodin, Percocet). NOTE: Has been doing this for at least the past 6 months or more, requesting increased dosage & quantity.

(Dept. Exhibit 3, p. 89; T 547.)

11. Neither the Respondent nor his employees had previously documented changes in the Respondent's behavior or other observed changes related to the prescribed opioid pain medications. (Dept. Exhibit 3.)

PATIENT B

12. On or about and between July 3, 2012 and September 20, 2014, the Respondent performed multiple surgical procedures on Patient B (a 48-year-old female at the inception of treatment who was employed by the Respondent), including 81 excisional biopsies on Patient B's head, neck, torso and extremities. Although the patient notes and operative reports identify

the wound closure procedures performed as flap reconstructions and advancement flaps, respectively, the patient records contain no description of how the flaps were created. (Dept. Exhibit 9; T 40, 518-19.)

13. On March 13, 2013, the Respondent excised two abdominal scars from Patient B, one from the left upper quadrant and another from the left lower medial quadrant. Pathological review indicated that no melanocytic proliferation was identified. Despite this finding, the Respondent re-excised the same scars on March 21. The pathological report again revealed that no melanocytic proliferation was identified. Re-excising the wound in such a short period of time is a departure from generally accepted standards. (Dept. Exhibit 9; T 155.)

14. On or about and between July 3, 2012 through September 2, 2014, the Respondent submitted 70 claims for payment to Patient B's insurer pertaining to the removal of Patient B's lesions for testing and closure of the resulting wounds. The Respondent's submitted claims characterized these wound closures as pedicle flaps under CPT codes in the 15570 series, procedures requiring the formation of a direct or tubed pedicle, with or without transfer. (Dept. Exhibits 9, 11a, 15; T 56.)

PATIENT C

15. On or about and between March 25, 2014 and April 16, 2014, the Respondent performed multiple plastic surgery procedures on Patient C, a 47-year-old female, including more than 20 excisional biopsies and closures of the resulting wounds. Although the patient notes and operative reports identify the wound closure procedures performed as flap reconstructions and advancement flaps, the records contain no description of how the flaps were created. (Dept. Exhibit 12; T 518-19.)

16. On or about and between March 25, 2014 and April 16, 2014, the Respondent submitted 19 claims for payment to Patient C's insurer for the excisional biopsies and closures of the resulting wounds. The Respondent's submitted claims characterized the wound closures as pedicle flaps under CPT codes in the 15570 series, procedures requiring the formation of a direct or tubed pedicle, with or without transfer. (Dept. Exhibits 12, 14, 15; T 56.)

PATIENT D

17. On or about and between April 16, 2014 and April 30, 2014, the Respondent performed multiple plastic surgery procedures on Patient D, a 46-year-old male, including eight excisional biopsies and closures of the resulting wounds. Although the patient notes and operative reports identify the wound closure procedures performed as flap reconstructions and advancement flaps, these records contain no description of how the flaps were created. (Dept. Exhibit 13; T 518-19.)

18. On or about and between April 16, 2014 and April 30, 2014, the Respondent submitted 7 claims for payment to Patient D's insurer for the excisional biopsies and closures of the resulting wounds. The Respondent's submitted claims characterized the wound closures as pedicle flaps under CPT codes in the 15570 series, procedures requiring the formation of a direct or tubed pedicle, with or without transfer. (Dept. Exhibits 13-15; T 56.)

RECREDENTIALING APPLICATIONS

19. On June 6, 2012, Department Nurse Investigator Jean Carazza-Mahoney sent the Respondent a letter by certified mail, return receipt requested, advising the Respondent that the

> Office of Professional Medical Conduct (OPMC)...is authorized to investigate instances or complaints of suspected professional misconduct. The Office is currently investigating your medical conduct...the issues under investigation involve the care you rendered to [Patient A]...[s]pecifically, the medical necessity of the procedures performed and the number of narcotic analgesics prescribed. (Dept. Exhibit 21.)

20. On July 24, 2012, Department Nurse Investigator Jean Carazza-Mahoney transmitted a letter via facsimile and certified mail, return-receipt requested to the Respondent, in care of his attorney, Ralph Erbaio, Esq, which advised in pertinent part:

> This will confirm our telephone conversation of July 24, 2012. During that conversation, I informed you that the Office of Professional Medical Conduct is investigating your professional conduct...The issues under investigation involve the care you rendered to [Patient A]...[s]pecifically, the medical necessity of the procedures performed and the number of narcotic analgesics prescribed. (Dept. Exhibit 21.)

21. By letter dated March 20, 2013 sent via certified mail, return-receipt requested, Department Medical Conduct Investigator Alice Ruby advised the Respondent that he was afforded an additional opportunity to participate in an interview pertaining to the Department's investigation of his "professional medical conduct." The Respondent's attorney was also provided a copy of this letter. (Dept. Exhibit 21.)

22. On August 8, 2013, the Respondent submitted an application for reappointment to the medical staff of St. Luke's-Roosevelt Hospital Center (St. Luke's). On page 7 of the application, entitled "Disciplinary Actions," the Respondent answered "No" to the following questions:

> 1. Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished or under investigation:
>
> a. Medical License in any state
>
> ***
>
> 9. Have you been the subject of any professional misconduct investigations or proceedings in New York State or any other State since the time of your last appointment/re-appointment? (Dept. Exhibit 17.)

23. On January 22, 2014, the Department advised the Respondent via certified mail, return-receipt requested, of an order issued by the Director of the OPMC to require the Department to conduct a comprehensive review of the Respondent's patient records and requiring the

Respondent to "cooperate with the investigation." The Respondent's then-attorney also received a copy of the correspondence and Director's Order. (Dept. Exhibit 21.)

24. On November 20, 2014, the Respondent's attorney supplied the Department's Medical Conduct Investigator Alice Ruby with five patient records requested in furtherance of the Department's comprehensive review of the Respondent's records. (Dept. Exhibits 9 and 13.)

25. By letter dated July 20, 2015 sent via certified mail, return-receipt requested, the Department advised the Respondent that the Department "is authorized to investigate instances or complaints of suspected professional misconduct. OPMC is currently investigating your medical conduct." The letter also specified "the issues under investigation." (Dept. Exhibit 21.)

26. On September 22, 2015, the Respondent submitted an application for reappointment to St. Luke's medical staff. On page 7 of the application, entitled "Disciplinary Actions," the Respondent answered "No" to the following questions:

> 1. Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished or under investigation:
>
> a. Medical License in any state
>
> ***
>
> 9. Have you been the subject of any professional misconduct investigations or proceedings in New York State or any other State since the time of your last appointment/re-appointment? (Dept. Exhibit 18.)

DISCUSSION

The Department presented two witnesses: Robert Grant, M.D., M.Sc., F.A.C.S., Plastic Surgeon-in-Chief at New York-Presbyterian Hospital's combined divisions of plastic surgery; and Tammy Kahler, Senior Fraud Investigator at Cigna. The Respondent presented Gregory E. Rauscher, M.D., F.A.C.S., Senior Attending Plastic Surgeon at Hackensack University Medical

Center, and Jacqueline Thelian, Professional Coder. In addition, the Respondent testified on his own behalf.

Testimony of Tammy Kahler

At the Department's request, Ms. Kahler prepared fee comparisons for CPT codes in the 12000 (simple and intermediate repairs), 13000 (complex repairs) and 15570 series based upon the Respondent's billing to CIGNA for Patient B. (Dept. Exhibit 11a.) Ms. Kahler's documentation demonstrated the difference in reimbursement under CPT codes in the 12000, 13000 and 15570 series. However, the Committee did not place any weight upon Ms. Kahler's testimony in rendering its determination as she was incapable of rendering an opinion as to whether the Respondent's submission of claims using CPT codes in the 15570 series was inappropriate or inaccurate.

Testimony of Dr. Grant

Dr. Grant has been the Chief of Plastic Surgery at New York Presbyterian Hospital since 1999, and now also serves as the System Chief of Plastic Surgery for the New York-Presbyterian enterprise. In his capacity as Chief of Plastic Surgery, Dr. Grant supervises 11 full-time plastic surgeons, volunteer faculty, and surgical residents. He supervises curriculum and training of residents. Dr. Grant's medical practice consists of aesthetic surgery and adult reconstructive surgery. He routinely removes pigmented skin lesions. Dr. Grant also has a great familiarity with medical billing and coding practices and teaches these practices to residents. (Dept. Exhibit 19; T 19-25.)

Dr. Grant was asked to review the medical records of Patients A and B. In addition, he performed his own examination of Patient A several days before he testified at the hearing on June 15, 2018. Dr. Grant concluded that the Respondent's records for Patients A and B

frequently contained insufficient justification for the excisions, as the Respondent failed to record the "ABCDE" characteristics of the lesions and frequently excised lesions less than 6 millimeters in diameter, which Dr. Grant testified was inappropriate. Additionally, Dr. Grant found no support for the Respondent's billing for wound closures as pedicle flaps, which he defined as "a flap that has a discrete blood supply supplying the territory that is being transferred." (T 37-38, 43.) Dr. Grant explained that advancement flaps, as the wound closures were referenced by the Respondent in the patients' medical records, are not synonymous with pedicle flaps. An advancement flap entails lifting the subcutaneous tissue off the fascia of the muscle, joining those two pieces of tissue, and closing the incision in a line. It was Dr. Grant's opinion that the wound closures performed by the Respondent constituted intermediate or complex wound closures, but not pedicle flaps. (T 44-45.)

The Hearing Committee appreciated Dr. Grant's thorough, expert testimony. They found that he elucidated the academic and training components of the professional standards in plastic surgery. The Committee placed great emphasis on Dr. Grant's testimony because he is tasked with overseeing residents and instructing residents on proper coding, including the need to accurately document procedures performed in real-time.

Testimony of Dr. Rauscher

Dr. Rauscher is a board-certified plastic surgeon and a professor of plastic surgery at Rutgers Medical School. He serves as a consultant for technical aspects of plastic surgeries at other hospitals. Dr. Rauscher serves on numerous plastic surgery research boards, and has served on medical ethics committees for the state of New Jersey. (Resp. Exhibit F; T 241-53.) In addition to his professional experience, Dr. Rauscher is diagnosed with dysplastic nevi or FAMM syndrome, a genetic mutation that causes dysplastic nevi (moles that are unusual in

appearance). These atypical moles are at risk of converting to malignant melanoma. Two of his four sons also have dysplastic nevi syndrome and his mother died from this condition. He treats many melanoma patients (at least one per week) because of his continued interest in the subject matter. (T 254-60.) Dr. Rauscher explained that a person is diagnosed with dysplastic nevi syndrome when two excised moles are found to be dysplastic. He noted that the diameter (the "D" in the ABCDE criteria) of the mole is not dispositive in determining the need to remove a lesion. (T 255-57.)

Dr. Rauscher was also asked to review the medical records of Patients A and B and concluded that the treatment that the Respondent provided to both patients was medically appropriate. (T 259.) He testified that the Respondent had included the ABCDE factors in Patient A's chart and that it was inappropriate to rely on the diameter of samples given to the laboratories for evaluation as a basis for alleging that the Respondent inappropriately excised lesions because the specimens shrink throughout testing. Dr. Rauscher also explained that certain patients have "micro-melanomas" which may be less than 6 mm in diameter, but are also 5 mm thick and therefore Stage 3 or Stage 4 cancer. (T 263-71, 291, 295.) He recalled having excised 250 moles from one patient in one sitting. (T 364.)

Dr. Rauscher determined that the Respondent properly documented the relevant ABCDE characteristics of lesions in both Patient A's and Patient B's records. With respect to Patient A, Dr. Rauscher identified several documented instances of the Respondent removing a lesion greater than 6 mm in diameter. (T 271-78.) On reviewing Patient B's records, Dr. Rauscher found documentation from the Respondent describing at least six lesions greater than 6 mm in less than 3 months. (T 319-20.)

Dr. Rauscher also determined that the Respondent's excisions of Patient A's lesions were medically appropriate. (T 259-60.) He believed that Patient A showed a high probability of having dysplastic nevus syndrome, as several specimens larger than 6 mm were found to be dysplastic and the patient had experienced sunburn and had a large amount of sun exposure. Dr. Rauscher reported that over 50% of Patient A's excised lesions were found to be dysplastic nevi. (T 272-78.) He did not view the Respondent's treatment of Patient A, specifically the number of excisions in just over two years, to be excessive. (T 377.)

Dr. Rauscher acknowledged that many of his colleagues opt for a "wait and see" approach with respect to pigmented lesions; however, it is his practice to remove such lesions without waiting. (T 288-89.) Although he was not given Dr. Wang's report regarding Patient A's condition, Dr. Rauscher expressed respect for Dr. Wang. He has frequently referred patients to Dr. Wang for observation. (T 351.)

Dr. Rauscher also disagreed with Dr. Grant's assessment of the type of wound closures performed by the Respondent. He explained that there are currently many types of pedicles and that advancement flaps can be categorized as pedicle flaps. Dr. Rauscher confirmed that advancement flaps may resemble linear closures on a patient's skin and that, therefore, he did not believe it was possible to visually identify the type of closure performed on a patient. He also confirmed that pedicle flaps do not require a secondary defect (a surface incision separate from the excision of the defect.) (T 310-16.) In concluding that the creation of two advancement flaps constitute a pedicle, Dr. Rauscher cited General Principles of Plastic Surgery, by JG McCarthy. (Resp. Exhibit G; T 321-22, 327-29.)

With respect to the use of various CPT codes for wound closures, Dr. Rauscher stated that his billing company normally utilizes the CPT codes corresponding to complex closures.

However, he acknowledged that his billing company has occasionally utilized the CPT code 15570 series (pedicle flap), depending on the defect. (T 317-18.) Dr. Rauscher noted that the procedures described by the Respondent in 2008 through 2014 would qualify as either a complex closure or a pedicle flap, and described the debate over which CPT code to use as "controversial." (T 344-45, 360.)

The Hearing Committee found Dr. Rauscher's testimony to be very informative, as he offered his own professional and personal experience in a subcategory of skin cancer relevant to Patients A and B. They found that Dr. Rauscher was, in certain ways, less detailed than Dr. Grant with respect to technical requirements for wound closures and coding. However, he provided a candid and practical overview of working with patients who present with pigmented lesions. The Committee members gave Dr. Rauscher's testimony equal weight to that of Dr. Grant regarding skin cancer and the different courses of treatment.

Testimony of Jacqueline Thelian

Ms. Thelian is certified by the American Academy of Professional Coders and has worked as a professional coder for 27 years, conducting compliance audits, teaching coding courses through the American Academy of Professional Coders, and has published a medical coding book and various articles on the subject. (Resp. Exhibit H.) She has worked with coding plastic surgery wound procedures for approximately three to five years. (T 462.) Ms. Thelian was asked to review the Respondent's operative reports and patient records and formulate an opinion as to the propriety of the CPT codes that the Respondent used for wound closures of all four patients. (T 394-95, 397, 446.)

Ms. Thelian concluded that the Respondent appropriately submitted claims using CPT codes in the 15570 series (pedicle flaps) because it was a "toss up" between billing under the

14000 code series (adjacent tissue transfers) and the 15570 series. While Ms. Thelian generally regards the CPT coding software as offering clarification or better coding guidance, she asserted that she could find no instructions that distinguished between the two series of codes. (T 399-400.) She explained that she intended to contact the American Medical Association (AMA) for clarification, something that she has never done before over the course of her 27-year career. (T 400-401, 422.)

In reaching her opinion on the matter, Ms. Thelian utilized Encoder Pro, coding software that offers information from the AMA. She determined that the 13000 series of codes (complex wound repairs) did not apply to the wound closures at issue because the CPT Assistant (a published coding resource) "clearly states in there, once a flap is created, you are not to use the complex codes." (T 402-03; Resp. Exhibit I.) Upon eliminating the 13000 series of codes, Ms. Thelian was left with deciding whether the Respondent should have billed the wound closures under the 14000 CPT code series or the 15570 code series used by the Respondent. Since the CPT code descriptors had not changed since the year 2000, Ms. Thelian confirmed that the confusion regarding the use of codes in the 14000 or 15570 series existed between the years 2008 and 2013. (T 420.)

Ms. Thelian testified that the CPT AMA manual does not require the creation of a secondary site defect in order to use the 14000 and the 15570 series of procedure codes. (T 427, 472.) In addition, she retrieved the CPT Assistant March 2010 newsletter, which defined a pedicle flap as "as a segment of tissue transferred to fill a defect while maintaining its own original blood supply" and "a portion of skin and subcutaneous tissue raised from its bed at one end and moved to another part of the body, while one end, the pedicle, remains attached to its original blood supply at the donor site." (T 440-41.) She acknowledged the difficulty in

determining the appropriate code to capture the Respondent's performed wound closures, particularly since he used the word "advancement" to describe the closures (a term used in both sets of codes) without descriptions of how the incisions were made and the flaps moved. (T 443-44, 498-99.) However, after asking additional questions of the Respondent as to how he created the flaps, she concluded that "a case could be made for either" the 14000 or the 15570 series. (T 495.) The Hearing Committee found Ms. Thelian's testimony informative, as she offered insight into the process of CPT code selection.

Testimony of the Respondent

In response to the concerns raised by Dr. Grant regarding the Respondent's failure to document the "ABCDE" characteristics of a lesion in patient records, the Respondent explained that he only documented the characteristics that applied "most dramatically" to a patient. He asserted that the presence of two or three of the indicators would warrant excision. (T 529-30.) However, the Respondent also explained that he does not immediately require biopsies of lesions and tends to be vigilant to any changes or progression in the lesions instead of excising several lesions at a time, particularly when a patient has many such lesions. (T 523.)

The Respondent testified that he still believes that the excisions that he performed on Patients A-D were medically necessary, reasonable and appropriate. (T 519.) He also confirmed that he closed the excision-related wounds for Patients A-D with advancement flaps, as he had written in the patients' operative reports. (T 519.)

With respect to Patient A, the Respondent first noticed a lesion that looked unusual on Patient A's chest while injecting fat into the patient's chest wall. He began discussing the lesion with Patient A shortly after surgery and advised the patient to observe the lesion for any changes. The Respondent recalled being particularly concerned about the possibility that the lesion would

convert into melanoma after Patient A informed him that he had had a severe sunburn as a child. (T 525-26.) He confirmed that he does not consistently document discussions with patients about the risks and benefits of excision. (T 527-28.) The pathology report from Patient A's first excisional biopsy revealed that the lesion was a dysplastic nevus with atypia. (T 531-32.)

The Respondent acknowledged controversy among physicians as to the probability that a dysplastic nevus will convert to melanoma, with predicted percentages ranging from 6-10%, 18%, and 32.4%. (T 533-36.) The Respondent explained that when a dysplastic nevus converts to melanoma, it spreads rapidly. (T 532.) Although the melanoma is indistinguishable from the appearance of the nevus before conversion, it becomes very dangerous because it may spread to the rest of the body very quickly. (T 545.)

The Respondent testified that his treatment of Patient B differed from his approach to Patient A because Patient B had a diagnosis evolving into melanoma at a conversion rate of 35.6%. (T 540.) He stated that Patient B was very concerned with her condition and asked the Respondent to follow changes in her lesions closely. When changes were observed, the Respondent acted more "aggressively and more quickly" than he had with Patient A's lesions. (T 541-42.) The Respondent explained that it was normal and recommended to remove an additional 2 mm margin from the lesion site. (T 554, 561, 578.)

The Respondent also described the way in which he closed the excision-related wounds using advancement flaps. Although the Respondent said that it would be easier to create a secondary defect when closing wounds, he prefers not to create an additional defect because it creates more scarring. (T 569-70.) He explained that he generally dissects into the skin, creating a flap, and moving with his scissors until reaching a perforating vessel, which is developed until the blood supply can be moved. (T 567.) The Respondent testified that he only cuts deep into

the skin for precursors of melanoma. (T 573.) However, after effectuating the wound closure, the Respondent insisted that the wound closure would appear to be a straight line on the skin's surface. (T 574.)

The Respondent confirmed bearing ultimate responsibility for his medical biller's submission of insurance claims in which these wound closures were characterized as pedicle flaps, rather than advancement flaps. (T 714.) Nevertheless, he sought to distance himself from his coder's decision to use the 15570 series of codes (which also yielded higher reimbursement rates over the 14000 series,) as he testified that he only began to research whether advancement flaps could constitute pedicle flaps after the inception of OPMC's investigation into his billing practices. He explained that he was not involved in the financial aspects of his practice. (T 616-17, 630, 632, 704-07.) It was inconceivable to the Committee that the Respondent was unaware of, or removed from, information pertaining to his office's profitability.

With respect to prescribing opioid pain medications to Patient A, the Respondent explained that it was very unusual for him to prescribe the quantities of these medications that were given to Patient A. However, he stated that the patient was a "large person" at a height of six feet, two inches and weighing 250 pounds. Moreover, the Respondent noted that the period in which he prescribed these medications was very different, "where undertreatment was very, very harshly recognized at the time." (T 679.) Although the Respondent testified to having relied on the 2011 Physicians' Desk Reference for guidance in prescribing the pain medications to Patient A, the Respondent failed to offer into evidence the complete section to which he referred. (T 674-85.) As such, the Committee could not conclude that the then-current version of the Physicians' Desk Reference supported the Respondent's actions.

The Committee noted that the Respondent made no contemporaneous notes regarding the opioid prescriptions issued to Patient A. (T 676, 680, 754.) Also of concern was the Respondent's acknowledgement of having issued prescriptions to Patient A well before surgeries. (T 681-82, 697-98.) When asked about his employee's notation regarding Patient A's aggression in the patient's records, the Respondent characterized the employee's observation as subjective and explained that she more readily viewed behavior as aggressive when the Respondent would not interpret such behavior similarly. (T 733-35.)

Regarding his responses to the St. Luke's recredentialing applications, the Respondent testified that he did not understand before or while completing the applications that OPMC's correspondence and inquiries were a means of investigating whether he had engaged in professional misconduct. He stated that he did not recall ever receiving a letter from OPMC advising him that he was under investigation for professional misconduct, despite confirming his receipt of all but one letter from OPMC regarding his treatment and care of Patient A and several other patients. The Respondent stated that he felt bound by the rules of confidentiality not to disclose OPMC's inquiries. (T 641-60, 745-51.)

The Committee was unclear as to the purpose of the Respondent testifying that OPMC's investigation was confidential. They could only surmise that the Respondent sought to convey that he failed to disclose that he was the subject of an investigation because he was bound by the rules of confidentiality. The Respondent's curriculum vitae notes that the Respondent was a consultant for OPMC. At the hearing, the Respondent confirmed having assisted OPMC with medical misconduct investigations. (Resp. Exhibit J; T 702-03.)

The Hearing Committee found the Respondent's testimony to be self-serving and circuitous, particularly regarding his interpretation of OPMC's correspondence and inquiries.

The Respondent's testimony regarding his reading of OPMC's letters and his decision not to advise St. Luke's of the investigation was found not credible.

It was evident to the Committee that the Respondent repeatedly sought to deflect personal responsibility to other individuals who were not present, namely, his prior attorney, and his former medical biller. The Hearing Committee was not persuaded by his purportedly blind reliance on these individuals, given the Respondent's substantial intelligence and professional experience.

CONCLUSIONS

As required by PHL § 230(10)(f), the Hearing Committee based its conclusions on whether the Department met its burden of establishing that the allegations contained in the Statement of Charges were more probable than not. When the evidence was equally balanced or left the Hearing Committee in such doubt as to be unable to decide a controversy either way, then the judgment went against the Department (*See* Prince, Richardson on Evidence § 3-206 [Farrell 11th ed]).

FACTUAL ALLEGATIONS NOT SUSTAINED[3]

Patient A

The Department charged the Respondent with knowingly and falsely representing on insurance claims that he utilized skin pedicle flaps for wound closure of excisional biopsies on Patient A's head, neck, torso and extremities with the intent to deceive (A.1.) on the following dates: January 23, 2009; February 20, 2009; June 16, 2009; July 23, 2009; October 2, 2009; November 20, 2009; December 21 and 28, 2009; January 11, 2010; February 2 and 15, 2010; March 15 and 29, 2010; April 12 and 26, 2010; June 8, 2010; July 20 and 26, 2010; November 8

[3] All findings in this section are unanimous unless otherwise noted.

and 15, 2010; December 8 and 15, 2010; and January 3, 2011. (A.1(a)-(y).) The Respondent was also charged with deviating from medically accepted standards if he had utilized skin pedicle flaps for wound closure of Patient A's excisional biopsies. (A.2.) In addition, the Respondent was charged with inappropriately advising Patient A, on or about February 16, 2011, that he faced significant risk of melanoma for which he recommended a series of further excisional biopsies. (A.3.)

The Committee finds (2-1) that there was insufficient evidence to establish that the Respondent's wound closures did not constitute pedicle flaps. Even though the Respondent himself referred to the wound closure as advancement flaps in the operative reports, the procedures might meet the criteria for pedicle flaps. Although Dr. Grant, the Department's expert, testified unequivocally that the wound closures were linear closures (T 48), the Respondent's medical expert cited a respected medical treatise in support of the position that the closures performed by the Respondent would be considered pedicle flaps and that an observer would be unable to ascertain whether the closure was a linear closure or a pedicle flap. (T 311-12.) Furthermore, the Committee finds that the Department provided no evidence that the use of skin pedicle flaps for wound closure of excisional biopsies was a deviation from medically accepted standards as Dr. Grant confirmed that the Respondent had achieved wound closure successfully.. (T 110.)

The Department's factual allegation A.3 was based upon a notation in Patient A's file whereby Patient A purportedly confirmed that he wished to hold off on further excisions, despite having previously believed that the 5-15% conversion rate of the dysplastic nevi to melanoma was too great a risk. (Dept. Exhibit 3; T 547.) Dr. Grant and Dr. Rauscher both confirmed that it was appropriate for Patient A to sign such advisement. As both the Department's medical expert

and the Respondent's medical expert concurred that the Respondent's actions were proper, the Department failed to establish that the Respondent's advisement to Patient A of his health risks was inappropriate. (T 63, 285-86.)

Patient B

The Department charged the Respondent with knowingly and falsely representing on insurance claims that he utilized skin pedicle flaps for wound closure of Patient B's excisional biopsies, with intent to deceive (B.1), on the following dates: July 3, 24, and 25, 2012; August 1, 28, and 29, 2012; September 5, 12, 25, and 26, 2012; October 9, 2012; December 31, 2012; February 6, 12, 22, and 27, 2013; March 5, 13, 16, 17, 20-22, and 27, 2013; April 1, 2, 9, 17, and 24, 2013; May 1, 8, and 28, 2013; June 13, 18, and 26, 2013; July 3, 23, and 24, 2013; August 13 and 20, 2013; September 3, 23, and 24, 2013; November 26, 2013; December 30, 2013; January 15 and 20, 2014; and September 2, 2014. (B.1(a)-(vv).) For the same reasons explained in the discussion regarding Patient A above, the Committee finds (2-1) that the Department failed to establish that the Respondent's wound closures did not constitute pedicle flaps.

The Respondent was also charged with deviating from medically accepted standards if he had utilized skin pedicle flaps for wound closure of Patient B's excisional biopsies. (B.2.) For the same reasons explained in the discussion regarding Patient A, the Committee finds that the Department provided no evidence that the use of skin pedicle flaps for wound closure of excisional biopsies was a deviation from medically accepted standards.

With respect to Patient B, the Department also alleged that the Respondent ordered excessive treatment not warranted by the patient's condition, with respect to multiple excisional biopsies performed on or about and between July 3, 2012 and December 2016. (B.3.) While the Committee agreed that the Respondent performed a large number of excisions on this patient

over a fairly short period of time, the Committee noted that the Department placed significantly less emphasis on Patient B's treatment than Patient A's treatment, leaving the Committee with insufficient information upon which to find that the excisions were indeed excessive and not warranted by this patient's condition. The Committee observed that Patient B was already diagnosed with melanoma, thereby heightening the concern of a treating physician that other lesions would also convert to melanoma. Upon comparing the approaches offered by Dr. Grant and Dr. Rauscher, the Committee could not conclude that the number of excisions performed on Patient B were excessive.

Patient C

The Department charged the Respondent with knowingly and falsely representing on insurance claims that he utilized skin pedicle flaps for wound closure of Patient C's excisional biopsies, with intent to deceive (C.1), on the following dates: March 25, 2014; April 8, 2014; and April 16, 2014. (C.1 (a)-(c).) For the same reasons explained in the discussion regarding Patient A above, the Committee finds (2-1) that the Department failed to establish that the Respondent's wound closures did not constitute pedicle flaps.

The Respondent was also charged with deviating from medically accepted standards if he had utilized skin pedicle flaps for wound closure of Patient C's excisional biopsies. (C.2.) For the same reasons explained in the discussion regarding Patient A above, the Committee finds that the Department provided no evidence that the use of skin pedicle flaps for wound closure of excisional biopsies was a deviation from medically accepted standards.

Patient D

The Department charged the Respondent with knowingly and falsely representing on insurance claims that he utilized skin pedicle flaps for wound closure of Patient D's excisional

biopsies, with intent to deceive (D.1), on the following dates: April 16 and April 30, 2014. (D.1 (a)-(b).) For the same reasons explained in the discussion regarding Patient A above, the Committee finds (2-1) that the Department failed to establish that the Respondent's wound closures did not constitute pedicle flaps.

The Respondent was also charged with deviating from medically accepted standards if he had utilized skin pedicle flaps for wound closure of Patient D's excisional biopsies. (D.2.) For the same reasons set forth in the discussion regarding Patient A above, the Committee finds that the Department provided no evidence that the use of skin pedicle flaps for wound closure of excisional biopsies was a deviation from medically accepted standards.

CONCLUSIONS OF LAW[4]

The Respondent is charged with sixteen Specifications of Charges of professional misconduct under Educ. Law § 6530. The Committee unanimously concludes that the Fifth, Sixth, Eleventh through Fourteenth, and Sixteenth Specifications are sustained. However, the Committee concludes (2-1) that the First through Fourth Specifications and the Seventh through Tenth Specifications are not sustained. In addition, the Committee unanimously concludes that the Fifteenth Specification is not sustained.

Fraudulent Practice – Educ. Law § 6530(2)

The First through Sixth Specifications charged the Respondent with committing professional misconduct as defined in Educ. Law § 6530(2) by practicing medicine fraudulently with respect to insurance claims he submitted for wound closures of excisional biopsies for

[4] In reaching its determination, the Committee used the definitions set forth in the memorandum entitled "Definitions of Professional Misconduct under the New York State Education Law." The parties were provided with a copy of the memorandum. In his opening statement on the first hearing date, Committee Chairman Dr. Lapidus advised the parties that the Committee may use the memorandum to assist them in rendering a determination, and invited the parties to "comment or dispute" the explanations provided in the memorandum before the last hearing date. However, neither party disputed or sought modification of the definitions. (T 5.)

Patients A, B, C, and D, and for concealing that he was the subject of a professional misconduct investigation on his August 8, 2013 and September 22, 2015 applications for reappointment to St. Luke's medical staff. The Committee concludes unanimously that the Fifth and Sixth Specifications are sustained. However, the Committee concludes (2-1) that the First through Fourth Specifications are not sustained.

"Fraudulent practice," in the specific context of a professional misconduct proceeding, is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine and with the intent to deceive. Choudhry v. Sobol, 170 A.D.2d 893 (3rd Dept. 1991), citing Brestin v. Commissioner of Education, 116 A.D.2d 357 (3rd Dept. 1986). To sustain a charge that a licensee has engaged in the fraudulent practice of medicine, the Hearing Committee must find that: (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed; (2) the licensee knew the representation was false; and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D.2d 315 (3rd Dept. 1966), aff'd. 19 N.Y.2d 679 (1967). Fraudulent intent may be inferred from evidence that the licensee was aware of the true state of facts at the time false responses were given. Saldanha v. DeBuono, 256 A.D.2d 935, 681 N.Y.S.2d 874 (3rd Dept. 1998.)

With respect to the Respondent's performing multiple excisional biopsies of Patients A-D and submitting insurance claims wherein he represented having closed the excision wounds with pedicle flaps, the Committee finds (2-1) that the Department's First through Fourth Specifications are not sustained. The Committee considered that the testifying medical experts offered different approaches with respect to patients that presented with pigmented lesions, and that fraudulent intent could not be gleaned from the Respondent's actions. Whereas Dr. Grant

deemed excision to be appropriate treatment for patients possessing all or most of the ABCDE factors, Dr. Rauscher acknowledged that his approach differed. Dr. Rauscher also testified that he had performed considerably more excisions on one particular patient on a single date of service. (T 377.)

In addition, both Ms. Thelian and Dr. Rauscher testified that it was difficult to decide what CPT codes to use for the wound closures that the Respondent performed for all four patients in the time period when those services were rendered. In addition, Dr. Rauscher cited a respected authority, General Principles of Plastic Surgery, by JG McCarthy, as demonstrating that the Respondent's wound closures are considered pedicle flaps. (Resp. Exhibit G.) Ms. Thelian advised that this area of the CPT code manual is ambiguous and would enable the Respondent to bill under either the 14000 CPT code series or the 15570 series that he had used. Dr. Rauscher also testified that Dr. Grant's mere observation of Patient A's scars after the fact would not enable him to understand what type of wound closure was performed. Due to the existence of controversy with respect to the appropriate terminology, character, and CPT coding, the Hearing Committee does not sustain these specifications.

With respect to the recredentialing applications that the Respondent submitted to St. Luke's on August 8, 2013 and September 22, 2015, the Hearing Committee carefully considered the timeframe within which the Respondent completed the applications, along with the wording of the questions on the applications. In both applications, the Respondent checked off the "No" box in response to two questions which unequivocally inquired whether the Respondent was under investigation, specifically, due to his medical licensure and professional misconduct in New York State or any other state. (Dept. Exhibits 17-18.)

The Respondent was first advised that his conduct was the subject of a professional misconduct investigation by letter dated June 6, 2012, more than one year before the Respondent's submission of the August 8, 2013 recredentialing application. After the June 6, 2012 letter but before the Respondent's August 8, 2013 application for continued hospital privileges at St. Luke's, the Department sent the Respondent two more letters regarding the ongoing investigation, one of which confirmed a telephone conversation between the Department's investigator and the Respondent himself. (Dept. Exhibit 21.)

The Department sent an additional three letters regarding the ongoing investigation between the Respondent's submission of his August 8, 2013 and September 22, 2015 recredentialing applications. The Respondent has assisted the Department with professional misconduct proceedings. (Resp. Exhibit J; T 702-03.) Nevertheless, the Respondent explained that he had not disclosed that he himself was the subject of a professional misconduct on the recredentialing applications because he was advised that the investigation was confidential and that they were not to be disclosed. (T 659-60, 744-46.) While the Respondent claimed reliance on the advice of counsel in cooperating with the Department's investigation of his medical conduct, the Respondent did not testify that his attorney had advised him to make a false representation on his applications for reappointment to St. Luke's. (T 648-60.)

The Hearing Committee was not persuaded by the Respondent's explanation because he was aware of the ongoing investigation, had received multiple letters describing the nature of the investigation, and had himself assisted with similar investigations in the past. As such, the Committee finds that the Respondent had made false representations to St. Luke's on both recredentialing applications which he knew were false, and that he intended to mislead, given his awareness of the true state of facts.

False Report – Educ. Law § 6530(21)

The Seventh through Twelfth Specifications charged the Respondent with willfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department, based upon the Respondent's performing excisional biopsies on Patients A-D, filing insurance claims in which he represented that he closed the excision wounds with pedicle flaps, and by concealing that he was the subject of a professional misconduct investigation on two recredentialing applications submitted to St. Luke's. The Hearing Committee finds (2-1) that the Seventh through Tenth Specifications are not sustained, but finds unanimously that the Eleventh and Twelfth Specifications are sustained.

As discussed above, the Hearing Committee recognizes the existence of controversy concerning the characterization of the wound closure procedures performed by the Respondent. Inasmuch as the Department was unable to establish by a preponderance of the evidence that the Respondent had performed complex wound closures, and not wound closures that could be considered pedicle flaps in the years 2008 through 2014, the Hearing Committee does not sustain (2-1) the Seventh through Tenth Specifications. The dissenting Committee member would have sustained these specifications on the grounds that the Respondent's records lacked documentation to prove the existence of pedicle flaps and also because the Respondent's operative reports merely note that advancement flaps were created without further description.

The Committee determined to sustain the Eleventh and Twelfth Specifications, which pertained to the Respondent's submission of recredentialing applications on August 8, 2013 and September 22, 2015. In both applications for continued hospital privileges at St. Luke's, he responded that he was not the subject of an investigation pertaining to his medical license and his professional conduct. The Department established that the Respondent was aware of an ongoing

investigation well before the Respondent submitted his August 8, 2013 recredentialing application and that, through continued correspondence, the Respondent was repeatedly advised that such investigation was ongoing, thereby eliminating any reasonable avenue for confusion when the Respondent submitted the September 22, 2015 application. There was no legitimate possibility of misunderstanding the nature of the Department's inquiry, as all correspondence advised him that he was under investigation. The Committee unanimously sustains the Eleventh and Twelfth Specifications.

Negligence on More Than One Occasion – Educ. Law § 6530(3)

The Department's Thirteenth Specification charged the Respondent with practicing the profession of medicine with negligence on more than one occasion, based upon the Respondent's: performing multiple excisional biopsies on Patients A-D and deviating from medically accepted standards by using pedicle flaps for wound closures; inappropriately advising Patient A that he faced a significant risk of melanoma; the Respondent's prescribing of Percocet and Vicodin to Patient A between May 18, 2010 and January 19, 2011; ordering excessive treatment not warranted by the condition of Patient B, with respect to multiple excisional biopsies performed on or about and between July 3, 2012 through December 2016; and re-excising Patient B's scars from excisional biopsies within an unacceptably short period of time between the initial excision and the re-excision. The Hearing Committee unanimously finds that the Thirteenth Specification is sustained.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Bogdan v. New York State Board for Professional Medical Conduct, 195 A.D.2d 86, 88 (3rd Dept. 1993). Injury, damages, and proximate cause are not essential elements in a medical disciplinary proceeding. Id. An act of negligence

regarding a single patient repeated on a subsequent occasion constitutes misconduct. Orosco v. Sobol, 162 A.D.2d 834 (3rd Dept. 1990.)

The Department did not establish by a preponderance of the evidence that the Respondent's performance of multiple excisional biopsies for Patients A-D constituted a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. The Department did not establish that Dr. Grant's method of determining whether to excise lesions was the standard practice from which the Respondent deviated. Rather, the record reflects that experts have different approaches to treatment of pigmented lesions. Dr. Rauscher expressed less hesitation with respect to excising lesions and confirmed that the Respondent documented the characteristics of each patient's lesions. Dr. Rausoher also testified that he had performed far more excisions on one patient on one date of service than the Respondent had performed on Patients A-D overall. (T 364, 377.)

However, the Hearing Committee finds that the Respondent's prescription of opioid pain medications to Patient A constitutes a failure to exercise the care of a reasonably prudent physician, even though the Committee agrees with the Respondent that those prescriptions were issued during a period in which physicians were encouraged to maximize pain control. (T 675-76.) In reviewing the evidence and testimony, the Hearing Committee finds that the Respondent acted negligently when prescribing Percocet and Vicodin to Patient A between May 18, 2010 and January 19, 2011.

Only the Department's medical expert (Dr. Grant) was asked whether the Respondent acted reasonably in prescribing these opioid pain medications to Patient A. Dr. Grant testified that the Respondent had written multiple prescriptions for opioid pain medication totaling nearly

450 tablets of extremely high strength two months before any major body procedure was done. As he explained:

> ...even if the patient was to have discomfort after the body contouring procedure in 2010, that amount of pain medicines [sic] to be given to a patient for us is – jumps out to be wildly excessive for that period of time.

(T 68-71.)

The Respondent confirmed that he prescribed these medications to Patient A before planned surgeries. He explained that he was comfortable issuing additional prescriptions to the patient before he had finished using previously-filled prescriptions because Patient A did not rush to fill the next prescription. (T 678-83.) The Committee considered the note made by the Respondent's employee on February 16, 2011, which refers to Patient A's aggression "for at least the past 6 months or more," during which the patient sought increased dosage and quantity of pain medications. (Dept. Exhibit 3, p.89.) The Committee finds that the Respondent failed to document the patient's pain, drug history, and his tolerance to various medications. He only charted Patient A's prescriptions, including the dates in which he filled those prescriptions, to cooperate with a Drug Enforcement Agency (DEA) investigation in the year 2013, well after the end of the physician-patient relationship. (T 678.)

Although the Respondent testified that the manner in which he prescribed pain medications to Patient A was an anomaly, the Hearing Committee was presented only with the Respondent's prescriptions of pain medication to Patient A, which they find inappropriate and constituting a failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. (T 679.) Furthermore, despite the Committee's acknowledgement of the Respondent's contention that he wrote these prescriptions during a period in which physicians were advised that a failure to control pain was a form of "undertreatment," the

Respondent's failure, at minimum, to document earlier changes in Patient A's behavior resulted in repeated prescriptions of opioid pain medications without medical justification which appear to have caused the patient's behavioral changes and placed him at risk of addiction.

In addition, the Hearing Committee finds that the Respondent's re-excision of Patient B's scars from excisional biopsies were effectuated within an unacceptably short period of time between the initial excision and the re-excision. As an example, the Respondent excised two abdominal scars from Patient B on March 13, 2013, sites where the Respondent had previously excised lesions. Although the pathology report found no evidence of melanocytic proliferation, the Respondent re-excised the same scars on March 21. Dr. Grant testified that re-excising the wound in such a short period of time is a departure from generally accepted standards. (Dept. Exhibit 9; T 155.)

Despite Dr. Rauscher's professed tendency to excise lesions rather than observe them, he too confirmed that he "would probably have waited a little – two months or something to see maybe if the patient is just healing funny." (T 374.) Noting that both medical experts found the Respondent's two re-excisions to have been excessive, the Committee determined that there was no logic to the Respondent's re-excisions of these scars, especially within approximately 30 days of the initial excision, and less than two weeks between the re-excisions. The Committee found no benefit derived from the repeated re-excisions. For these reasons, the Thirteenth Specification is sustained.

Incompetence on More than One Occasion – Educ. Law § 6530(5)

The Fourteenth Specification charged the Respondent with committing professional misconduct as defined in Educ. Law § 6530(5) by performing multiple excisional biopsies on

Patients A-D, re-excising skin pedicle flaps for closing the resulting wounds of Patients A-C[5], inappropriately advising Patient A that he faced a significant risk of melanoma for which he recommended additional excisional biopsies, inappropriately prescribing Percocet and Vicodin on or about and between May 18, 2010 and January 19, 2011, ordering excessive treatment for Patient B in the form of multiple excisional biopsies not warranted by the patient's condition, and re-excising Patient B's scars from excisional biopsies within an unacceptably short period of time between the initial excision and the re-excision. The Committee concludes unanimously that the Fourteenth Specification of incompetence on more than one occasion is sustained.

Incompetence is a lack of the requisite skill or knowledge to practice medicine safely. Dhabuwala v. State Board for Professional Medical Conduct, 225 A.D.2d 209 (3rd Dept. 1996). As discussed above, the Department did not establish that the Respondent's performing multiple excisional biopsies for Patients A-D was not appropriate or that the use of skin pedicle flaps constituted a deviation from medically accepted standards. Nor did the Department establish that the Respondent acted inappropriately or incompetently by advising Patient A in writing of the consequences of his decision to postpone indefinitely further excisions. However, the Committee considered the sustained factual allegations relevant to this Specification which, when viewed in tandem, satisfy Educ. Law § 6530(5).

The Hearing Committee found that the Respondent showed a lack of the requisite knowledge to practice medicine safely when issuing prescriptions to Patient A for high dosages and large quantities of Percocet and Vicodin over an eight-month period. Most disconcerting was the Respondent's issuance of these prescriptions without proper patient charting for drug

[5] This specification references a factual allegation "D3" which purportedly pertained to Patient D. However, the amended Statement of Charges does not contain a factual allegation labeled D3. As such, the Committee disregarded the Department's insertion of D3 in this specification.

interactions, pain tolerance, or even dates upon which the prescriptions were filled and the quantities dispensed. In addition, the Respondent's issuance of these prescriptions bore minimal relation to planned surgeries. The Respondent's employees had a documented awareness of changes in Patient A's behavior relating to these prescriptions for at least 6 of the 8 months in which the Respondent prescribed the opioid pain medications to him. His failure to discuss these issues with the patient and adjust his prescribing practices accordingly posed grave risks to the patient.

The Committee also viewed the Respondent's repeated re-excision of Patient B's scars as demonstrating the Respondent's lack of knowledge to practice medicine safely. As discussed above, the pathology report for the first re-excision showed no cause for concern. Yet, the Respondent again re-excised the scar very shortly afterward. The Respondent's overall testimony concerning Patient B characterized the patient as very concerned with her condition and seeking more aggressive treatment. (T 541-42.) Although it was appropriate for the Respondent to discuss treatment with Patient B, the Respondent bears ultimate responsibility for treatment-related decisions. The Respondent's continued re-exposure of this patient's wounds to additional procedures without medical justification showed the Respondent's lack of knowledge to practice medicine safely. For these reasons, the Committee sustains the Fourteenth Specification.

Ordering Excessive Treatment – Educ. Law § 6530(35)

The Fifteen Specification charged the Respondent with committing professional misconduct as defined in Educ. Law § 6530(35) by ordering excessive treatment not warranted by Patient B's condition. This specification cited fact finding B (the Respondent's removal of

multiple excisions from Patient B) and B.3 (a factual allegation not sustained by the Committee.) The Hearing Committee unanimously concludes that this specification is not sustained.

As explained above, the medical experts expressed very different views with respect to whether the Respondent performed excessive excisional procedures. Regarding Patient B specifically, the Committee noted that this patient had already received a melanoma diagnosis, thus deepening a concern by a physician that Patient B's other lesions would pose similar risks. When a patient presents with pigmented lesions, a physician must decide whether to excise those lesions or observe them (i.e., the "wait and see" approach.) The Department did not establish that the Respondent performed excessive excisions on Patient B.

Moral Unfitness- Educ. Law § 6530(20)

The Sixteenth Specification charged the Respondent with committing professional misconduct as defined in Educ. Law § 6530(20) by engaging in conduct in the practice of medicine that evidences moral unfitness to practice, with respect to the multiple excisional biopsies performed for Patients A-D, the submission of insurance claims in which the Respondent billed for pedicle flaps as the method by which he closed the excision-related wounds for Patients A-D, advising Patient A of the risks associated with his decision to postpone further excisions, inappropriately prescribing Percocet and Vicodin to Patient A, and concealing on two recredentaling applications that he was the subject of a professional misconduct investigation. The Hearing Committee unanimously sustains this charge.

The Hearing Committee concludes that the Respondent's repeated submission of applications for hospital privileges at St. Luke's containing material, false information showed that he was willing to jeopardize the safety of the public at large in order to continue to generate revenue related to surgical procedures that required his use of an operating room. As a physician

who has served as a consultant to the Department in other misconduct investigations, the Respondent's justification for actively concealing that he was himself the subject of such an investigation was unacceptable. For these reasons, the Committee sustains this specification.

HEARING COMMITTEE'S DETERMINATION AS TO PENALTY

Although the Respondent's attorneys argued that the Department failed to meet its burden of establishing the factual allegations and specifications in the SOC, the Respondent acknowledged that he has now learned to include more detail in his operative reports to describe wound closure procedures. (T 596.) In addition, the Respondent confirmed that his responses to the questions in the St. Luke's recredentialing applications pertaining to his involvement in misconduct investigations would be different today, although he did not previously believe that he had answered the questions falsely. (T 653, 657.)

The Department argued that all the factual allegations and specifications of charges should be sustained and that the Respondent's license to practice medicine in the State of New York should be revoked. After reviewing the entire record, wherein some charges and specifications have been dismissed, the Committee unanimously concludes that the allegations and specifications that were sustained do not warrant a revocation of the Respondent's license.

The Hearing Committee has considered the full range of sanctions available pursuant to PHL § 230-a, including: censure and reprimand; suspension, wholly or partially, with or without terms or conditions; revocation; limitation on further licensure; monetary penalties; a course of education or training; performance of public service; and probation. Pursuant to the Findings of Fact and Conclusions of Law set forth above, and after due deliberation, the Committee unanimously determines that the appropriate sanction is a suspension of the Respondent's medical license for a period of eighteen (18) months and the completion of the following courses

which must be approved in advance by the Director of OPMC: (1) coding; (2) pain management; (3) clinical documentation; and (4) controlled substances.

In rendering its determination to require the Respondent to complete the aforementioned courses, the Committee took into consideration the sustained findings of fact, including the inappropriate prescribing of opioid pain medications to Patient A well before planned surgeries, and after members of the Respondent's staff had noted changes in the patient's behavior. The Committee also noted the repeated instances during the hearing in which the Respondent's documentation was identified as inadequate to justify patients' conditions and the types of wound closures performed. In addition, the Committee found the Respondent's two re-excisions of Patient B's scarring to have been inappropriate and a deviation from medically acceptable standards.

The Committee's determination to impose a suspension of 18 months was based on the totality of the facts that were sustained, especially the Respondent's material misrepresentations on two reappointment applications to St. Luke's that he was not the subject of any investigation. The Committee was not satisfied by the Respondent's explanation regarding his inaccurate responses as resulting from an advisement that the proceedings were confidential. The Respondent received multiple letters from OPMC regarding the investigation into the treatment that he rendered first to Patient A and then to several other patients before submitting his recredentialing applications. The Committee found it implausible that the Respondent (a consultant for OPMC in other investigations) could not have understood the importance of disclosing such information to a hospital where he sought to maintain privileges. They therefore inferred from the Respondent's actions that he intended to conceal this information as such concealment enabled him to continue to service his patients and earn income without disruption.

The Hearing Committee concludes that a suspension, combined with course requirements, would enable the Respondent to correct the deficiencies cited in this decision.

ORDER

IT IS HEREBY ORDERED THAT:

1. The following charges of misconduct under Educ. Law § 6530 are sustained:

Educ. Law § 6530(2) –	practicing the profession fraudulently
Educ. Law § 6530(21) –	willfully making or filing a false report
Educ. Law § 6530(3) –	practicing the profession with negligence on more than one occasion
Educ. Law § 6530(5) –	practicing the profession with incompetence on more than one occasion
Educ. Law § 6530(20) –	conduct in the practice of medicine which evidences moral unfitness to practice medicine

2. The following charge of misconduct under Educ. Law § 6530 is not sustained:

Educ. Law § 6530(35) – ordering of excessive treatment not warranted by the condition of the patient

3. Pursuant to PHL § 230-a(2)(a), the Respondent's license to practice medicine shall be suspended, wholly, for a fixed period of 18 months.

4. Pursuant to PHL § 230-a(8), the Respondent shall be required to complete courses of education during the 18-month period of suspension in the subject areas of coding, pain management, clinical documentation, and controlled substances, which shall be proposed by the Respondent and subject to written approval of the Director of OPMC.

5. This order shall be effective upon service of the Respondent by personal service or by certified mail as required under PHL § 230(10)(h).

DATED: New York, New York
December 2, 2018
January 2019

[redacted]

STEVEN M. LAPIDUS, M.D., Chair
THOMAS T. LEE, M.D., M.B.A.
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APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

JOSEPH MICHAEL POBER, M.D.

AMENDED STATEMENT OF CHARGES

JOSEPH MICHAEL POBER, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 7, 1980 by the issuance of license number 144489 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between April 2008 and January 2011 the Respondent, a plastic surgeon, performed multiple procedures on Patient A, including but not limited to excisional biopsies on Patient A's head, neck, torso and extremities. Patient A, a 25-year-old male at the onset of treatment, and the other patients in the Statement of Charges are identified in the attached Appendix.

1. On or about the dates below, Respondent knowingly and falsely represented on insurance claims that he utilized skin pedicle flaps for wound closure of excisional biopsies. Respondent intended to deceive.
   a. January 23, 2009.
   b. February 20, 2009.
   c. June 16, 2009.
   d. June 16, 2009.
   e. July 23, 2009.
   f. October 2, 2009.

g. November 20, 2009.
h. November 20, 2009.
i. December 21, 2009.
j. December 28, 2009.
k. January 11, 2010.
l. February 2, 2010.
m. February 15, 2010.
n. March 15, 2010.
o. March 29, 2010.
p. April 12, 2010.
q. April 26, 2010.
r. June 8, 2010.
s. July 20, 2010.
t. July 26, 2010.
u. November 8, 2010.
v. November 15, 2010.
w. December 8, 2010.
x. December 15, 2010.
y. January 3, 2011.

2. Alternatively, Respondent deviated from medically accepted standards, if, in fact, he utilized skin pedicle flaps for wound closure of excisional biopsies.
3. On or about February 16, 2011, Respondent inappropriately advised Patient A that he faced significant risk of melanoma for which he recommended a series of further excisional biopsies.
4. Respondent inappropriately prescribed Percocet and Vicodin on or about and between May 18, 2010 and January 19, 2011.

B. On or about and between July 3, 2012 and September 6, 2016, Respondent performed multiple procedures on Patient B, a 48-year-old female at the onset of

treatment, including but not limited to excisional biopsies on Patient B's head, neck, torso and extremities.

1. On or about the dates below, Respondent knowingly and falsely represented on insurance claims that he utilized skin pedicle flaps for wound closure of excisional biopsies. Respondent intended to deceive.
   a. July 3, 2012.
   b. July 24, 2012.
   c. July 25, 2012.
   d. August 1, 2012.
   e. August 28, 2012 (two claims).
   f. August 29, 2012.
   g. September 5, 2012.
   h. September 12, 2012
   i. September 25, 2012 (three claims).
   j. September 26, 2012.
   k. October 9, 2012.
   l. December 31, 2012 (two claims).
   m. February 6, 2013.
   n. February 12, 2013
   o. February 22, 2013.
   p. February 27, 2013.
   q. March 5, 2013. (two claims).
   r. March 13, 2013.
   s. March 16, 2013. (three claims)
   t. March 17, 2013.
   u. March 20, 2013.
   v. March 21, 2013.
   w. March 22, 2013.
   x. March 27, 2013.
   y. April 1, 2013.

z. April 2, 2013.

aa. April 9, 2013 (two claims)

bb. April 17, 2013 (two claims).

cc. April 24, 2013 (two claims).

dd. May 1, 2013.

ee. May 8, 2013.

ff. May 28, 2013 (five claims).

gg. June 13, 2013 (two claims).

hh. June 18, 2013.

ii. June 26, 2013 (two claims).

jj. July 3, 2013.

kk. July 23, 2013.

ll. July 24, 2013.

mm. August 13, 2013.

nn. August 20, 2013.

oo. September 3, 2013 (two claims).

pp. September 23, 2013.

qq. September 24, 2013

rr. November 26, 2013 (three claims).

l. December 30, 2013 (two claims).

ss. January 20, 2014.

tt. January 15, 2014 (two claims).

uu. January 20, 2014

vv. September 2, 2014.

2. Alternatively, Respondent deviated from medically accepted standards, if, in fact, he utilized skin pedicle flaps for wound closure of excisional biopsies.

3. Respondent ordered excessive treatment not warranted by the condition of Patient B, with respect to multiple excisional biopsies performed on or about and between July 3, 2012 and through December 2016.

4. Respondent re-excised scars from excisional biopsies within an unacceptably short period of time between the initial excision and the re-excision.

C. On or about and between March 25, 2014 and April 16, 2014, the Respondent performed plastic surgery procedures on Patient C, a 47- year-old female, including multiple excisional biopsies.

1. On or about the dates below, Respondent knowingly and falsely represented on insurance claims that he utilized skin pedicle flaps for wound closure of excisional biopsies. Respondent intended to deceive.
   a. March 25, 2014 (three claims).
   b. April 8, 2014. (nine claims).
   c. April 16, 2014 (seven claims).
2. Alternatively, Respondent deviated from medically accepted standards, if, in fact, he utilized skin pedicle flaps for wound closure of excisional biopsies.

D. On or about and between April 16, 2014, and April 30, 2014, the Respondent performed a variety of plastic surgery procedures on Patient D, a 46-year-old male, including multiple excisional biopsies.

1. On or about the dates below, Respondent knowingly and falsely represented on insurance claims that he utilized skin pedicle flaps for wound closure of excisional biopsies. Respondent intended to deceive.
   a. April 16, 2014 (four claims).
   b. April 30, 2014 (three claims).
2. Alternatively, Respondent deviated from medically accepted standards, if, in fact, he utilized skin pedicle flaps for wound closure of excisional biopsies.

E. Respondent concealed, with intent to deceive, that he was the subject of a professional misconduct investigation on multiple applications for the reappointment to the medical staff of Saint Luke's Roosevelt Medical Center that he signed on the dates below:

1. August 8, 2013.
2. September 22, 2015.

SPECIFICATION OF CHARGES

FIRST THROUGH SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. A, A1 and/or A1(a) through A1(y).

2. B, B1 and/or B1(a) through B1(vv).

3. C, C1 and/or C1(a) through C1(c).

4. D, D1 and/or D1(a) through D1(b).

5. E and E1,

6. E and E2.

SEVENTH THROUGH TWELFTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

7. A, A1 and/or A1(a) through A1(y).

8. B, B1 and/or B1(a) through B1(vv).

9. C, C1 and/or C1(a) through C1(c).

10. D, D1 and/or D1(a) and/or D1(b).

11. E and E1.

12. E and E2.

THIRTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of

13. Paragraphs A, A2, A3, A4, B, B2, B3, B4, C, C2, D and/or D3.

FOURTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

14. Paragraphs A, A2, A3, A4, B, B2, B3, B4, C, C2, D and/or D3.

FIFTEENTH SPECIFICATION

ORDERING EXCESSIVE TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering excessive treatment not warranted by the condition of the patient, as alleged in the facts of:

15. B and B3.

SIXTEENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

16. A, A1(a)-A1(y), A3(a) A(4), B, B1(a)-B1(w), B3, C, C1(a)-C1(c), D, D1(a)-D1(b) E1, and/or E2.

DATE: June 19, 2018
New York, New York

[redacted]

Henry Weintraub
Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

PRACTICE CONDITIONS

1) Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of this Consent *Order* and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(29).

2) Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of the Conditions in Exhibit B. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

3) The conditions imposed in Exhibit B shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30-day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the conditions imposed in Exhibit B shall resume and Respondent shall fulfill any unfulfilled conditions and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "B" or as are necessary to protect the public health.

4) The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

5) Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

6) Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

7) _Commencing upon the conclusion of the period of active license suspension, Respondent shall practice medicine in New York only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Such approval shall not be unreasonably withheld. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20 and no more than 40) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

d) Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18) (b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

8) Respondent shall comply with this Consent Order and all its terms and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a professional misconduct proceeding to enforce a violation of any condition of this Consent Order, and/or any other such proceeding authorized by law, against Respondent.